STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

BULLETIN

ATTENTION: All insurers writing workers' compensation insurance, self insured plans and self insured groups.

Tennessee's anti-fraud statue,T.C.A. 56-47affects all workers compensation insurers, self insurers, and self insured groups. New insurers and self insured employers or self insured groups should file a plan no later than their acceptance by the Department. Insurers no intending to produce this line of business will find a form following this bulletin which these companies are requested to file with the department. A filing will be due for those companies only if, and when, they begin writing this line of business

YOU MUST:

A. FILE AN ANTI-FRAUD PLAN
B. REPORT ALL SUSPECTED FRAUD
C. SUBMIT AN ANNUAL SUMMARY REPORT
D. POST A MANDATED FRAUD NOTICE

A. **FILE AN ANTI-FRAUD PLAN:**

T.C.A. 56-47 requires every workers compensation insurer--including self insurers-- prepare, implement, and maintain an anti-fraud plan. The plan must be submitted for approval to:

Department of Commerce and Insurance
Coit Holbrook, CPCU, CIE
Director of Consumer Services
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243-5341
Phone: 615-532-5341 or 1-800-792-7573
Fax: 615-532-7389

Each plan shall outline specific procedures to:

1) Prevent, detect, and investigate all forms of workers' compensation fraud, including:

1a) fraud involving insurer's employees or agents

1b) Fraud resulting from misrepresentation in the application 1c) Fraud in renewal or rating of policies

1d) Data processing and computer security fraud

1e) Claims fraud by claimants, providers, or professional and investigative services

2) Educate employees on fraud detection and the in house anti-fraud plan

3) Provide for the hiring of, or contracting with, fraud investigators

4) Report workers' compensation fraud to appropriate law enforcement and regulatory authorities for the purpose of investigating and prosecuting perpetrators

5) Pursue restitution for financial loss caused by fraudulent activities

To make compliance with the new law easier, we have developed an anti-fraud plan guideline and forms for your use. The model plan guidelines may be ordered, if you desire, in hard copy or diskette form (WordPerfect format on a 3.5 inch disk). An order form is included with this bulletin. You must customize the plan to meet the requirements of your company and to include the specific procedures described in numbers 1 to 5 above. A fraud plan that your company already has in place that complies with the new law may be submitted. All companies should promptly notify all their Tennessee agents and employees of the provisions of this plan. At any time the plan is modified, a copy of the modified plan is to be refiled with the Department of Commerce and Insurance.

B: **FRAUD REPORTING:**

Determine the type of fraud according to the list in section A 1 a through e in anti-fraud plan above:

Sections (a) to (d) deal with company and agent fraud and should be reported to:

Fraud and Special Investigations Unit
Department of Commerce and Insurance,
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243-5341
Phone: 615-532-5341 or 1-800-792-7573
Fax: 615-532-7389

Section (e) deals with fraudulent activities of claimants, providers, and professional services and should be reported to:

Tennessee Department of Labor
Director or Workers' Compensation
Attn. Ed. Finchum, Supervisor
710 James Robertson Parkway
Andrew Johnson Tower, 2nd Floor
Nashville, TN 37243-0661
Phone: 615-532-1836

C. **ANNUAL SUMMARY REPORT FILING**

To assure compliance with the spirit of the law an annual summary of action taken under the anti-fraud plan must be submitted by the end of the first quarter of the each subsequent year. Reports for the year 2000 are due March 31, 2001. The report should included but not limited itself to:

a) Describe anti-fraud training claims employees received
b) Describe steps to detect fraud in company employee's and agents
c) Describe steps to detect fraud in modulation rates by insured
d) Describe steps to detect fraud in claims by insured employees
e) Describe steps to detect data processing fraud
d) Describe steps to detect misrepresentation by consumer
f) Summarize cases referred to appropriate authorities.
g) List the amounts of monetary recoveries.
f) Discuss possible organized criminal activities

D. **MANDATED NOTICE:**

All printed applications for insurance, and all printed claim forms provided and required by an insurer or required by law as a condition of payment of a claim, shall contain a statement, permanently affixed to the application or claim form, that clearly states in substance the following:

> "It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits."

All other filings and inquires regarding these requirement should be directed to;

Department of Commerce and Insurance
Coit Holbrook, CPCU, CIE
Director of Consumer Services
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243-5341
Phone: 615-532-5341 or 1-800-792-7573
Fax: 615-532-7389

REGISTRATION FORM FOR
WORKERS' COMPENSATION ANTI-FRAUD PLAN*

==========

Mark one box: Original Filing Refiling of Modified Plan

==========

Company Name:

_____

Contact Person:

_____

Position Title:

_____

Phone: (_____)-_____-

_____

Location Address:

_____

City:_____ TN___ZIP:_____

Mailing Address:

_____

City: _____ST: _____ZIP: _____

==========

Mark one box: [] Insurance Company [] Self-insured Employer [] Self-insured Group

==========Self-insured Employer or Group are you using a TPA to manage your plan? Yes No

TPA Name:

_____

Address:

_____

City: _____ ST: _____ ZIP: _____

Contact Person:

_____

Phone: (_____)-_____-

==========

Signed at: _____ By: _____

Date: _____ Title _____

*This form, or the information required by this form, must be a cover to your anti-fraud plan.

SUMMARY REPORT FORM FOR
WORKERS' COMPENSATION ANTI-FRAUD PLAN

Company Name:
_____

Report prepared by:
_____

Firm:
_____

Address: _____ State: _____ZIP:_____
==========
Reporting period:
==========

1. Describe the resources committed to the combating of fraud in this reporting period (number of employees, investigations performed by contracted investigators, costs of the resources used, etc.).

2. List the number of instances and amount of fraud discovered in this reporting period.

3. List the number and amount of recovery during this reporting period.

4. Describe, in as much detail as possible, any and all discovered criminal activities of an organized nature.

5. List the claim costs for discovered fraud from claims activity.

6. Describe the internal activities taken to detect fraud among company employees.

THIS FORM MUST BE SIGNED AND DATED

Signed: _____
Date:_____

WORKERS' COMPENSATION FRAUD REFERRAL FORM

Please type or print information (complete all applicable sections).
Date of Referral_____
Referral By:Insurance Co._____ Other_____
Referring Person _____Telephone#_____
Referred to Law Enforcement Agency: No__Yes___Who_____

REASON FOR REFERRAL (PLEASE ATTACH RELEVANT DOCUMENTS)
_____
_____
_____

CONTACT INFORMATION

Contact Person_____Telephone # _____
Address_____
Company Name_____Telephone #_____
Company
Address_____

Type of Workers' Comp Fraud: (Please mark applicable category)
_____ Claimant/Benefits Fraud (i.e, false application, staged accident, etc.)
_____ Premium Avoidance Fraud (i.e, payroll and/or employee misclassification, etc.)
_____ Agent Theft
_____Other_____

LOSS INFORMATION

Date of Accident/Loss_____ Location of Accident/Loss _____
Description of Accident/Loss _____
_____
_____
Insurance Claim# _____ Police Report # _____
Other Insurance Company Involved _____
Address_____
Contact Person_____Telephone#_____
Claim #_____Policy #_____
Value of Claim:$_____ Amount of Demand_____

SUSPECT INFORMATION

Name_____ Telephone #_____
Address_____
Date of Birth_____ SS#_____ Race_____ Sex_____Height_____
Weight__Hair___Eyes____ Scars/Marks/Tattoos_____
Vehicle:Year_____Make_____Model _____ Color_____
Tag#_____State__VIN#_____Driver'sLicense#_____State ____

VICTIM INFORMATION

Name of
Company_____
Address_____
_____ Telephone #_____
Contact Person_____ Telephone#_____
Name of Individual_____Telephone #_____
Address_____
Date of Birth_____ SS#_____ Race_____Sex_____

OTHERS INVOLVED

IDENTIFY ALL PRINCIPALS AND THEIR ROLES USING THE FOLLOWING:
ADJ- Adjuster; AGT- Agent; APP- Appraiser; ATT- Attorney; CHIRO- Chiropractor; CLMT- Claimant; INSD- Insured; MEDOC- Medical Doctor; PASS- Passenger; PHYS- Physical Therapist; WIT- Witness.

Name_____ Telephone #_____
Address_____Role_____

Name_____ Telephone #_____
Address_____Role_____

Name_____ Telephone #_____
Address_____ Role_____

Name_____ Telephone #_____
Address_____ Role_____

Name_____ Telephone #_____
Address_____Role_____

MAIL COMPLETED FORMS AND SUPPORTING DOCUMENTATION AS DIRECTED BELOW:

EMPLOYEE FRAUD	ALL OTHER FRAUD
Tennessee Department of Labor	Tenn. Dept. Of Commerce and Insurance
Attn: Ed Finchum	Attn: Director Coit C. Holbrook
Division of Workers'Compensation	Consumer Insurance Services
710 James Robertson Pky., 2nd Fl.	500 James Robertson Pky., 4th Fl.
Nashville, TN 37243-0661	Nashville, TN 37243-0574

To:

DEPARTMENT OF COMMERCE AND INSURANCE
Fraud & Special Investigations-4th Floor
500 James Robertson Parkway
Nashville, TN 37243-0574

From:

_____

Name:

_____

Company:

_____

Address:

_____

City: _____ ST: _____ ZIP: _____

Item	Cost	Quantity
Hard copy of the Tennessee model workers' compensation anti-fraud plan, printed on 8.5 by 11 inch paper	$10.00	_____
Tennessee model workers' compensation anti-fraud plan on 3.5 inch disk in WordPerfect format	$10.00	_____

Amount Enclosed $_____

Make checks payable to: Tennessee Department of Commerce and Insurance and enclose with copy of this form with company name and mailing address completed. Orders will be filled in the order received and in the shortest possible time.